C. M. A. DEPARTMENT OF PUBLIC RELATIONS

An open forum for progress notes on the department's activities, and for brief discussions on medical economics. Correspondence and suggestions invited. Address Walter M. Dickie, Room 2039, Four Fifty Sutter Street, San Francisco. This column is conducted by the Director of the Department.

THE ADMINISTRATION OF MEDICAL CARE

Some Principles Which Must Predominate In Any Plan

Some of the principles which have long predominated in the practice of medicine are stated below. In the interest of the public good and the future of the medical profession, there should be no lowering of standards because of financial stress or temporary expediency. On the contrary, it may be possible that these principles can be strengthened and others of importance may be added.

1. The welfare of the public is of primary importance. Exploitation of the public for economic advantage and financial gain is inimical to good medical service.

2. The unity of medical organization must be preserved for the protection of the public welfare and the advancement of medical science.

3. Free choice of physician must be guaranteed.

4. Opposition to unfair competition among physicians must be maintained. Any distribution of medical service which depends on compulsion for its acceptance and use establishes an unfair competition among physicians and introduces a monopolistic control of medical care.

5. Sacrifice of quality of medical service through the action of commercial competition must not be tolerated.

6. No form of solicitation or compulsion must be exercised on patients to compel them to enter into any system of medical care. Any deviation from this principle subjects medical qualifications and care unduly to financial considerations.

7. Full responsibility for the determination of professional qualifications and ethics and adequacy of medical service must be vested in the medical profession.

8. Compensation for medical care should be adequate to insure competent service.

9. Preventive or preclinical medicine must not be neglected.

10. Any change in the method of administering medical care should always be preceded by careful and thorough study by the medical profession. Change is justified only on the premise that the new methods to be adopted are superior to the old which they supplant.—R. G. Leland, M. D., *American Medical Association Bulletin,* October, 1932.

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AN EQUITABLE DISTRIBUTION OF GROUP INCOME

Based upon an experience of nearly ten years, I am suggesting the following method of equitably calculating the percentage of net income from a partnership or group practice unit, which should go to each member so that each member may receive as exactly as possible the amount he has earned.

The plan is to calculate the percentage of the various activities of the firm performed by each member: the work done in office calls, charged and free; the house and hospital visits, charged and free; the amount charged and the amount collected, and an arbitrary factor of good will.

Into this item of good will can be credited by mutual agreement all the obvious but unmathematical differences in value of each member to the firm; age, experience, length of residence, reputation, skill, specialty. For instance, the pathologist compared with the surgeon; the new member and the well-established member, etc. This proportionate value must be more or less arbitrarily fixed from time to time by mutual, frank discussion in the full spirit of coöperation and fair play. It is obvious that without this spirit no partnership or group can succeed.

In actual practice the figures work out as follows, the first figures being the percentage of the total work and calls for each member for the preceding month or six months. All of these figures except "good will" were taken from actual experience.

	Dr. A.	Dr. B.	Dr. C.	
Work Percentages				
Office—no charge	12.61	44.50	42.89	100%
Calls—no charge	18.97	48.15	32.88	100%
Total office	22.96	43.38	33.66	100%
Total calls	13.34	47.09	39.57	100%
400 per cent	67.88	183.12	149.00	
100 per cent	16.97	45.78	37.25	
Cash Percentages				
Business, per cent	20.47	45.79	33.74	100%
Cash total	24.78	44.34	30.88	100%
200 per cent	45.25	90.13	64.62	
100 per cent	22.62	45.07	32.31	
Final Percentage				
Work, per cent	16.97	45.78	37.25	100%
Return, per cent	22.62	45.07	32.31	100%
Good Will, per cent	35.00	40.00	25.00	100%
300 per cent	74.59	130.85	94.56	
100 per cent	24.86	43.62	31.52	

Final percentage to be used for distribution of net income to be applied to either a preceding period or to a succeeding one.

The items in the partnership agreement covering these calculations read as follows:

The secretary shall keep a careful record of all work done by each member. Such record shall show daily:

1. The amount of work done.
   a. Number of visits charged.
   b. Number of visits no charge.
   c. Number of office calls charged.
   d. Number of office calls no charge.
2. Monetary value to firm.
   a. Total earned.
   b. Total collected.

3. Such other records as may from time to time be agreed upon, as number of anesthesias, amount of laboratory work, number of operations, an arbitrary per cent allowance for surgical or other specialty fees, etc.

At the first of January and the first of July, or at more frequent intervals, a total of these records for each partner for the past six months shall be made and a percentage of the total work done by the partner for the past six months shall be made and a percentage of the total work done by each member shall be calculated in separate figures as measured in "work" and as measured in "monetary value" (marked "cash" on sheet), and as measured in "good will."

The total of these percentages gives an accurate picture of the relative worth to the firm of each member and form an equitable basis for the division of net income. These percentages may be made to apply to the past month or half year, or to the coming month

or other period, as desired. Other factors of earning capacity may be from time to time mutually agreed upon, *i. e.,* the number of operations, obstetric cases, laboratory work, anesthetics, etc.

New members can be easily added to the group or old ones permitted to withdraw by fixing the present value of assets by agreement or arbitration, and admission or release from this percentage calculation. The factor of "good will" acts as a buffer to adjust actual or fancied unmathematical values in personalities, mental equipment, skill, etc.

Twice each year for nearly ten years the sheets upon which these calculations were made were studied by each of the three members of the firm and at no time was there any suggestion of inequity in the final figures.

The calculations are simple percentages, and the several secretaries employed during this time had no difficulty at any time nor did they complain of the few minutes per day devoted to them.

I should have enjoyed trying it out on a group of ten or a dozen.

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VARIATION IN COST OF MEDICAL SERVICE

In formulating a medical service plan for group practice on a periodic payment basis, we have to consider the question of cost to the individual, and whether the same is within his ability to pay. Naturally the cost of medical service will vary according to the conditions existing in the individual community. In taking up the study of this subject, one cannot help but be impressed by the utter lack of statistical figures on the cost of medical service to the individual.

Dr. Michael M. Davis, in his book on "Paying Your Sickness Bills," sets forth various studies of small groups of families, one of which is a 12,000 family group which was surveyed by the United States Bureau of Labor Statistics. This number was divided in seven groups, according to their income per annum, ranging from those under $900, up to and including $2,500 and over. It is surprising to note that the percentage spent for medical care in all these groups was approximately four per cent of annual income, and the amount spent varied from $34 in the group whose income was under $900, to $95.56 in the group with incomes of $2,500 or over. The average amount spent was $60.39. There was a gradual increase according to the income of the family.

It is difficult to account for the large variation in costs unless we assume that those in the lower brackets of income received inadequate medical care.

We also have a study of another group of some 17,000 persons in which the average yearly expenditure per family amounted to $140. In this survey, one of our national life insurance companies found that in a group of 3,281 families among industrial policyholders, consisting of 17,129 persons, only 198 families reported no expenditure for sickness. However, a grand total of $230,907 was spent by all families, over a period of six months, making an average expenditure per family of $70, or $140 a year. Again the disproportionment of disbursements for sickness was marked: 64 per cent of the total amount having been expended by 20 per cent of the total number of families.

In a preliminary report made by the Committee on the Costs of Medical Care it was shown that out of a group of 4,560 families whose annual incomes varied from $2,000 to $5,000 that the average cost of sickness per family ranged from $71.48 in the lowest income group to $311.06 for the group with incomes of $5,000 or over. Families with incomes of less than $1,200 averaged $66 expenditure. Expenditures in all groups represented about five per cent of income.

From these figures and others that are available, it would seem that the average family of moderate means spends on an average of from $60 to $140 a year for medical service, there being a very rapid rise in expenditure with increased income. Expressed in terms of percentage the amount spent ranges between four and five per cent of annual income.

We have no way of determining whether or not the medical care in the lower brackets of income was in any way adequate, nor to what extent the services of a physician were employed. It would probably be more conservative to take the cost of medical care as indicated in the higher brackets, which would place the expenditure of the average family near the maximum average of $140, rather than the minimum average of $60 per year.

We also find that the cost of medical care varies according to the particular locality in which the study has been made. For instance, the cost of medical care shows a wide degree of variation between the eastern and western states, averaging $52 annual expenditure per family along the Atlantic seaboard, and $73 for the average family living in the West.

In a further analysis of the cost of illness, we find that a group study of 17,000 illnesses, made by the United States Public Health Service in Hagerstown, Maryland, recorded the following kinds of care:

	Per Cent
Private physicians	46.00
Medical care in hospital	1.34
Chiropractors and osteopaths	0.41
Self-medication	2.25
No form of care reported	50.00

In returning to the original survey of 12,000 families made by the United States Bureau of Labor Statistics, we find that the average annual expenditure of $60.39 per family was spent in the following manner:

For physicians	$32.17
For medicine	10.39
For dentist	8.23
For hospital care	4.56
For nursing care	3.02
For eyeglasses	1.75
For miscellaneous services, etc.	0.27

The foregoing surveys and others which have been made indicate the wide variance in the cost of medical care among families of moderate income, and just what the basis of a fee schedule should be can best be determined when some county medical society undertakes to furnish adequate medical service on a stipulated periodic payment plan.

Water-Front Safety Activities.—During the past five years there has been a constant effort to reduce the accident rate among the stevedoring companies and marine interests on the Pacific Coast. A steady improvement is noted. The Pacific Steamship Company at San Francisco has recently completed 100,000 longshoreman hours without a lost-time injury. Chief Stevedore Julius Tillman, supported by his immediate chief, Port Captain C. Hansen, and his operating manager, W. P. Bannister, has achieved this result. One gang boss has a record of over three years without a compensable injury. Too much credit cannot possibly be given to an organization of this sort when it accomplishes such work, and each man participating deserves to be congratulated.

Iodized Salt and Goiter Surgery.—McClure points out that there has been a tremendous reduction in the incidence of nontoxic diffuse goiter since the introduction of iodin salt in Michigan. There has also been a marked dropping off in the number of goiter operations in the Detroit and Ann Arbor areas since the introduction of this salt. The number of all operations has increased, so that relatively there is a still more marked drop. The author does not conclude from these facts that iodin deficiency is the only cause of goiter but he does believe that, if the thyroid can be kept in its normal state by a sufficient intake of iodin, toxic diffuse and nodular goiters are less apt to develop.—*Wisconsin Medical Journal,* August, 1932.